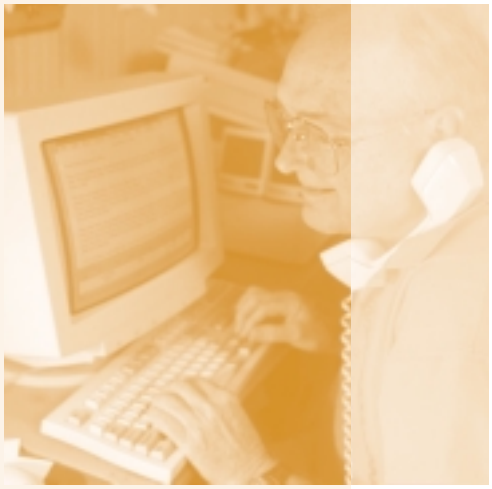

1 INTRODUCTION AND HIGHLIGHTS OF FINDINGS

Health and Health Care of the Medicare Population: Data from the 1997 Medicare Current Beneficiary Survey is the sixth in a series of Medicare beneficiary sourcebooks. The information presented here is drawn from the Medicare Current Beneficiary Survey (MCBS), a rotating panel survey of a nationally representative sample of aged and disabled Medicare beneficiaries. The MCBS is sponsored by the Centers for Medicare and Medicaid Services (CMS), under the general direction of its Office of Strategic Planning. Westat, a survey research organization with offices in Rockville, Maryland, is collecting and disseminating data for the first 10 years of the survey.

The MCBS is a comprehensive source of information on the health status, health care service use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of aged and disabled Medicare beneficiaries. Survey data are collected three times each year over 4 years, regardless of whether the beneficiary lives in a household or a long-term care facility. The resulting data are disseminated in annual public use files (PUFs) containing a cross-section of all persons entitled to Medicare during the year. The 1997 MCBS, for example, includes beneficiaries who were entitled to Medicare for all or part of the year, as well as beneficiaries who died in 1997. These data can be used for cross-sectional analyses, or linked to PUFs from previous years for longitudinal analyses of the Medicare population.

One of the strengths of the MCBS is its scope of information on personal health care utilization and expenditures. Respondents are asked about expenditures on Medicare-covered services and health services not typically covered by the Medicare program. Those services typically not covered by Medicare include purchases of prescription medicines, dental care, hearing aids, eyeglasses, and long-term care facility services. The MCBS also collects information on out-of-pocket payments, third party payers, and use of health care services provided by such agencies as the Veterans Administration to more fully understand the financing of services not covered by Medicare. This information is used in conjunction with Medicare claims data to determine the amounts paid by Medicare, Medicaid, other public programs, private insurance, and households for each medical service reported by a beneficiary.

Annual data from the MCBS are released to the public in two different PUFs. The Access to Care PUFs, available for calendar years 1991 through 1999, contain information on beneficiaries' access to medical providers, satisfaction with health care, health status and functioning, and demographic and financial characteristics. The files include Medicare claims data for beneficiaries who were enrolled in Medicare for the entire calendar year and were community residents (that is, the noninstitutionalized population).[1] They provide a snapshot of the "always enrolled" Medicare population, and can be used to analyze characteristics of beneficiaries who were potential or actual users of Medicare-covered services during the entire 12-month period.

The Cost and Use PUFs, available for calendar years 1992 through 1998, are more comprehensive than the Access to Care PUFs. The Cost and Use PUFs include information on services not covered by Medicare, and the samples are chosen to represent all beneficiaries who were ever enrolled in Medicare at any time during a calendar year. The Cost and Use PUFs also contain detailed information on health insurance coverage, as well as health status and functional capacity. The data can be used to analyze total and per capita health care spending by the entire Medicare population, including part-year enrollees and persons who died during the year.

The MCBS sourcebooks include information from both sets of PUFs. The 1997 sourcebook also uses data from previous PUFs. Chapter 2 contains information on emerging trends and patterns between 1992 and 1997. It has sections on growth in personal health care spending by Medicare beneficiaries, health insurance, high-cost users, funding sources, income inequality in the Medicare population, the correlation between health and socioeconomic status, access to care, and satisfaction with health care. Sections 1-5

[1] Beneficiaries who did not live in long-term care facilities are referred to as community residents in the sourcebook.

in Chapter 3 contain the same set of the cross-sectional data from the Access to Care and Cost and Use PUFs as previous sourcebooks. Section 6 data tables highlight emerging trends in health and health care utilization between 1992 and 1997.

Appendix A provides a description of the sample design, survey operations, response rates, and structure of the MCBS PUFs. It also includes a discussion of procedures to calculate standard errors for cross-sectional statistics and estimates of net change over time. Appendix B contains a glossary of terms and variables used in the detailed tables.

HIGHLIGHTS OF FINDINGS

The Medicare Population

Compared with the growth rate of the Medicare population for 1995-1996, the growth rate declined to 0.8 percent in 1996-1997, mostly due to the lack of growth in the aged population.

Personal Health Care Expenditures

From 1996 to 1997, the Medicare population's personal health care expenditures (PHCE) grew from $356 billion to $365 billion, representing a growth rate of 2.5 percent. This significantly low growth may be attributed to the rapid rise in managed care enrollment, an apparent slowdown in growth of the quantity and intensity of services, and relatively mild price inflation.

Per capita, PHCE of Medicare beneficiaries grew to $9,186, a 1.7 percent increase over 1996-1997. For the first time in recent years, the per capita growth for Medicare beneficiaries fell below that of non-Medicare beneficiaries, suggesting a significant slowdown in average personal health care spending growth.

High-Cost Users

Several groups of beneficiaries continued to show relatively high average PHCE in 1997, as they did in previous years. The highest per capita expenses were incurred by full-year nursing home residents (mostly because of room and board expenses not incurred by other beneficiaries), followed by Medicare/Medicaid dual eligibles, the oldest old, the disabled, and racial/ethnic minorities.

Several characteristics distinguish high-cost users (i.e., beneficiaries whose total PHCE was at the 99th percentile or above) from the general Medicare population. High-cost users tend to be disabled, male, non-Hispanic black, never married, with income less than $10,000, and spend at least part of the year in a nursing home. Beneficiaries with severe illnesses and/or disabling limitations tend to incur high costs and consume large amounts of intensive health care services (particularly inpatient hospitalizations and nursing home stays). Compared with the entire Medicare population, a significantly larger share of high-cost users' total PHCE is funded by public and other sources.

Funding Sources

Between 1996 and 1997, all sources of payment for the Medicare population indicate either a drop in spending level or a slowdown in spending growth for PHCE, reflecting the rapid structural change in health care and health insurance markets. Public funds covered more than two-thirds of PHCE incurred by Medicare beneficiaries.

Declining since 1993, the share of out-of-pocket payments of PHCE was 18.3 percent in 1997 for the Medicare population. Out-of-pocket spending grew by 1.2 percent, a significantly lower rate than the rates observed in recent years. The observed slowdown may in part be due to greater prevalence of supplemental coverage and a switch from standard indemnity coverage to enrollment

in Medicare HMOs. The amount of out-of-pocket spending by the average Medicare beneficiaries is more than three times the amount spent by the average non-Medicare beneficiary.

- For Medicare beneficiaries, the share of private health insurance (PHI) funding has decreased to 10.1 percent of PHCE in 1997, while growth of PHI funding has slowed to 1 percent. This may reflect the fact that many beneficiaries dropped PHI coverage in favor of Medicare managed care enrollment.

- Medicare contributed 55.7 percent of PHCE by Medicare beneficiaries in 1997, a growth of 1.6 percent between 1996 and 1997. Compared with the previous year, the growth of Medicare funding for PHCE has slowed to 4.3 percent. These trends may be the outcome of significant Medicare policy changes and intensified government fraud and abuse detection activities.

PHCE by Service Type

- Medicare beneficiaries' distribution of PHCE by type of service has changed only slightly between 1992 and 1997. During this period, the largest shares of spending have been for ambulatory, inpatient hospital, and nursing home care. In 1997, the share of prescription medicine spending reached 7.5 percent of PHCE, whereas the share of home health care declined to 4.7 percent.

- For the Medicare population, the slowdown in inpatient hospital spending may be attributed to the slowdown in Medicare payment rate increases, underscored by the Balanced Budget Act's (BBA) 1-year freeze on Prospective Payment System (PPS) rates for inpatient services, and the rapid growth of enrollment in Medicare managed care. Advances in technology and changes in insurer incentives may have resulted in the transfer of care to an ambulatory setting and shorter inpatient hospital stays. The financial incentives in the Medicare program are likely to cause a substitution away from inpatient hospital care and toward hospital outpatient departments, as reflected by Medicare beneficiaries' relatively high growth in hospital outpatient spending (7.9 percent) in 1997.

- Because Medicare is the largest source of funds for home health expenditures, the sharp drop in the growth of home health spending (–8.1 percent) funded by all sources is largely a result of the government's steps to control Medicare home health spending. These steps included policy changes affecting eligibility, coverage, and payment as well as intensified fraud and abuse detection activities.

- After several years of decelerating growth, spending on nursing homes by the Medicare population remained constant in 1997. The major source of funds for nursing homes is Medicaid; and the states, along with the Federal Government, fund Medicaid. Hence, recent Medicaid policy changes by many states to encourage greater use of alternative, lower-cost, treatment settings (such as home health, assisted living facilities, and community-based day care) may be responsible for the observed lack of growth.

- Spending on physicians/suppliers grew by 1.8 percent for the Medicare population in 1997. The relatively low growth may be attributed to changes in Medicare payment rate regulations under the Resource Based Relative Values Scale (RBRVS) and volume performance standards. Also, recent changes in physician practice patterns in response to broader changes in health care markets may have contributed to lower price growth for physician services.

- Prescription medicine (PM) spending by Medicare beneficiaries had the highest growth rate among all service types in 1997 (10.5 percent). This is largely due to greater PM coverage by third-party sources, rapid growth in the number of new PMs on the market, direct-to-consumer advertising, and the rapid growth in managed care enrollment, which usually entails low out-of-pocket

costs and first dollar coverage. Nonetheless, a large part of PM spending is paid for out-of-pocket by the average Medicare beneficiary.

Income

Between 1992 and 1997, the median income of all Medicare beneficiaries grew at an annual rate of 6 percent. For aged beneficiaries, median income grew by 8.1 percent in 1996-1997. While Medicare beneficiaries appear to be doing well in terms of income growth, there is significant variation across particular subgroups. For example, median income is lowest for full-year nursing home residents, higher for disabled community-only residents, and highest for aged community-only residents. In fact, poverty or low income is quite prevalent among the Medicare population. An estimated 14 percent of community residents and 43 percent of full-year nursing home residents live in poverty.

Health and Socioeconomic Status

Low-income beneficiaries living in the communities were more likely to report health problems than their high-income counterparts. In 1997, more than 40 percent of the beneficiaries in the lowest income quartile reported poor or fair health, compared with 17 percent in the highest-income quartile. Also, more beneficiaries in the lowest income quartile reported poorer health at younger ages than those in the highest income quartile.

Beneficiaries with low-income reported higher prevalence of chronic diseases. In 1997, beneficiaries in the lowest income quartile were more likely to report diabetes, mental illness, osteoporosis, and Alzheimer's disease than those in higher income quartiles.

Low-income beneficiaries were more likely to report functional limitations than the others. In 1997, more than 28 percent of the beneficiaries in the lowest income quartile reported at least one functional limitation, compared to 11.9 percent of the beneficiaries in the highest income quartile.

Insurance Status

Over the 1992 to 1997 period, Medicare community residents showed consistent declines in PHI coverage (both employer-sponsored and individually-purchased). During the same years, enrollment in Medicare HMOs increased at an annual rate of 20 percent. These trends are understandable in light of reduced employer-sponsored coverage offered to workers and retirees, the relatively high out-of-pocket costs required with PHI coverage (particularly for individually-purchased policies), and the low out-of-pocket costs that accompany enrollment in managed care.

Among the aged, Medicare HMO and employer-sponsored PHI decline as age increases, whereas participation in Medicaid rises with age—perhaps because spend-down is more likely as age rises and health deteriorates. Moreover, reliance on public sources of coverage is much more common for the disabled, who typically have relatively low incomes, than for the aged.

Access to Care

Access to care continued to improve among Medicare beneficiaries living in the communities. In 1997, nearly 94 percent of the beneficiaries reported having access to office-based physicians as their usual source of care, a 3.2 percent increase from 1992. At the same time, the proportion of beneficiaries reporting difficulty in obtaining care continued to decrease. Only about 3 percent of the beneficiaries encountered problems in getting care. Cost had become less of a concern among the Medicare beneficiaries. Less

than 7 percent of the beneficiaries residing in communities reported delaying care due to cost.

- Among the more vulnerable subgroups of Medicare beneficiaries, particularly those with low-income, the use of office-based physicians as usual source is reported more often than in the past. Both nonwhites and low-income beneficiaries reported less difficulty in obtaining care.

- While disabled beneficiaries reported improvement in access to office-based physicians as their usual source of care, they were still confronted with more challenges in obtaining care than the others, and were more likely to delay care because of cost.

- More beneficiaries without supplemental insurance (i.e., beneficiaries with Medicare fee-for-service-only) than others reported facing barriers to care. They were less likely to report using office-based physicians as their usual source of care. Fee-for-service-only beneficiaries also reported encountering more difficulty in obtaining care, and were more likely to delay care because of cost.

Satisfaction with Care

- Medicare beneficiaries residing in the communities remained highly satisfied with various aspects of their medical care. In 1997, more than 96 percent reported being either very satisfied or satisfied with the quality of health care. In particular, the upward trend in satisfaction with the cost of health care since 1992 continued in 1997.

- Among the beneficiaries of the vulnerable groups, the disabled were the least satisfied with the quality of their medical care. They reported more problems in getting care at night or on the weekend, and encountered more difficulty in getting care.

- The fee-for-service-only beneficiaries were least satisfied with the cost of care compared with other vulnerable groups, probably because they incurred higher out-of-pocket expense. Compared to other beneficiaries, the fee-for-service-only beneficiaries were also less satisfied with the quality of their medical care, the availability of getting care at night or on the weekend, and reported more barriers in obtaining care.